Proposed Substitute House Bill 1508 (H-1464.1/23)

House Appropriations Committee
By Representative Macri

Original Bill:

Directs the Health Care Cost Transparency Board (Transparency Board) to conduct an annual survey of underinsurance among Washington residents and a study of how state tax preferences affect the calculation of total health care expenditures. Authorizes the Transparency Board to require that payers or health care providers that frequently exceed the health care cost growth benchmark without a reasonable justification submit a performance improvement plan or pay a civil fine.

Proposed Substitute House Bill (H-1464.1/23) compared to the Original Bill:

- Prohibits the Health Care Cost Transparency Board (Transparency Board) from requiring any health care provider that is composed of 25 or fewer health care professionals from having to submit a performance improvement plan or pay a civil fine for data submission violations or exceeding the health care cost growth benchmark. Requires the Health Care Authority, when establishing a civil fine schedule, to account for the relative starting price position of the payer or health care provider in relation to the health care cost growth benchmark, including primary care expenditure goals. Requires the Health Care Authority to notify a health care provider or payer in advance of public notice when requiring them to either submit a performance improvement plan or pay a civil fine. Requires the Transparency Board to consider the same factors when determining whether or not to impose a performance improvement plan that it does when considering imposing a civil fine.
- Requires the agenda and materials related to the annual hearing on growth in total health care expenditures in relation to the health care cost growth benchmark be available to the public at least seven days before the meeting. Requires the annual report to include information about testimony and public comments received at the hearing.
- Requires the Transparency Board to seek input from relevant advisory committees before a major vote or decision, unless there are exigent circumstances. Allows advisory committees established by the Transparency Board to include stakeholders with expertise such as health care providers, payers, and health cost researchers.
- Adds to the items for the Transparency Board to consider when analyzing the impacts of cost drivers the following: (1) Utilization trends and adjustments for demographic changes and severity of illness, and (2) new state health insurance mandates that require carriers to reimburse the cost of specific procedures or prescription drugs.
- Requires calculations of total health care expenditures and cost growth for health care providers and payers to be both adjusted and unadjusted for patient health status and allows the Transparency Board to establish a common risk adjustment methodology, in consultation with the Advisory Committee on Data Issues and the Health Care Stakeholder Advisory Committee. Requires the Transparency Board's analyses to be performed by persons with relevant expertise. Allows the Transparency Board to use other non-specified data sources, such as Medicare cost reports.
- Removes outdated references and makes conforming amendments.

Staff: Chris Blake (OPR)
Date: February 23, 2023

BILL REQUEST - CODE REVISER'S OFFICE

BILL REQ. #: H-1464.1/23

ATTY/TYPIST: MW:jlb

BRIEF DESCRIPTION: Improving consumer affordability through the health care cost transparency board.

AN ACT Relating to improving consumer affordability through the health care cost transparency board; amending RCW 70.390.020, 70.390.040, 70.390.050, 70.390.070, 43.71C.030, and 70.405.030; adding new sections to chapter 70.390 RCW; creating a new section; and providing an expiration date.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

NEW SECTION. **Sec. 1.** (1) The legislature finds that:

(a) Although the legislature established the health care cost transparency board in 2020 and the board has established a health care cost growth benchmark to monitor cost growth, health care costs and spending continue to rise. According to the health care cost transparency board, research demonstrates that Washington's health care cost trends, particularly hospital and pharmacy costs, outpace other states and the national average;

(b) According to the commonwealth fund, Washington workers and businesses have seen double-digit increases for employer-based health insurance over the last decade, with the total average premium for a single worker rising by 49 percent and the deductible rising by 51 percent from 2010 through 2020;

(c) According to an analysis by the office of the insurance commissioner, health care spending in Washington's commercial market

grew by 13 percent from 2016 to 2019, even though inflation grew by only seven percent of this period;

(d) According to the office of financial management, health care spending now accounts for 20 percent of Washington's state general fund budget; and

(e) In a recent survey by Altarum, more than 60 percent of Washingtonians surveyed in 2022 reported experiencing a health care affordability burden in the last year. More than half of respondents reported delaying or skipping care due to cost. More than 80 percent of respondents said the government should set limits on health care spending growth and penalize payers or providers that fail to curb excessive spending growth.

(2) The legislature intends to empower the health care cost transparency board to accelerate its work to analyze the underlying drivers of health care cost growth, and further to take action to address outlier spending that exceeds the health care cost growth benchmark.

Sec. 2. RCW 70.390.020 and 2020 c 340 s 2 are each amended to read as follows:

(1) The authority shall establish a board to be known as the health care cost transparency board. The board is responsible for the analysis of total health care expenditures in Washington, identifying trends in health care cost growth, identifying drivers of health care cost growth, and establishing a health care cost growth benchmark. The board shall provide analysis of the factors impacting these trends in health care cost growth and, after review and consultation with identified entities, shall identify those health care providers and payers that are exceeding the health care cost growth benchmark. The board's analysis must be performed by individuals with relevant expertise.

(2) The authority is authorized to conduct activities necessary to support the activities and decisions of the board, including activities related to data collection and analysis and the enforcement of performance improvement plan submissions and the payment of fees and fines issued by the board pursuant to this chapter.

Sec. 3. RCW 70.390.040 and 2020 c 340 s 4 are each amended to read as follows:

(1) The board shall establish an advisory committee on data issues and ((~~an~~)) a health care stakeholder advisory committee ((~~of health care providers and carriers~~)). The board may establish other advisory committees as it finds necessary. Any other standing advisory committee established by the board shall include members representing the interests of consumer, labor, and employer purchasers, at a minimum, and may include other stakeholders with expertise in the subject of the advisory committee, such as health care providers, payers, and health care cost researchers.

(2) Appointments to the advisory committee on data issues shall be made by the board. Members of the committee must have expertise in health data collection and reporting, health care claims data analysis, health care economic analysis, ((~~and~~)) actuarial analysis, or other relevant expertise related to health data.

(3) Appointments to the health care stakeholder advisory committee ((~~of health care providers and carriers~~)) shall be made by the board and must include the following membership:

(a) One member representing hospitals and hospital systems, selected from a list of three nominees submitted by the Washington state hospital association;

(b) One member representing federally qualified health centers, selected from a list of three nominees submitted by the Washington association for community health;

(c) One physician, selected from a list of three nominees submitted by the Washington state medical association;

(d) One primary care physician, selected from a list of three nominees submitted by the Washington academy of family physicians;

(e) One member representing behavioral health providers, selected from a list of three nominees submitted by the Washington council for behavioral health;

(f) One member representing pharmacists and pharmacies, selected from a list of three nominees submitted by the Washington state pharmacy association;

(g) One member representing advanced registered nurse practitioners, selected from a list of three nominees submitted by ARNPs united of Washington state;

(h) One member representing tribal health providers, selected from a list of three nominees submitted by the American Indian health commission;

(i) One member representing a health maintenance organization, selected from a list of three nominees submitted by the association of Washington health care plans;

(j) One member representing a managed care organization that contracts with the authority to serve medical assistance enrollees, selected from a list of three nominees submitted by the association of Washington health care plans;

(k) One member representing a health care service contractor, selected from a list of three nominees submitted by the association of Washington health care plans;

(l) One member representing an ambulatory surgery center selected from a list of three nominees submitted by the ambulatory surgery center association; ((~~and~~))

(m) Three members, at least one of whom represents a disability insurer, selected from a list of six nominees submitted by America's health insurance plans;

(n) At least two members representing the interests of consumers, selected from a list of nominees submitted by consumer organizations;

(o) At least two members representing the interests of labor purchasers, selected from a list of nominees submitted by the Washington state labor council; and

(p) At least two members representing the interests of employer purchasers, including at least one small business representative, selected from a list of nominees submitted by business organizations. The members appointed under this subsection (3)(p) may not be directly or indirectly affiliated with an employer which has income from health care services, health care products, health insurance, or other health care sector-related activities as its primary source of revenue.

Sec. 4. RCW 70.390.050 and 2020 c 340 s 5 are each amended to read as follows:

(1) The board has the authority to establish and appoint advisory committees, in accordance with the requirements of RCW 70.390.040, and shall seek input and recommendations from ((~~the~~)) relevant advisory committees ((~~on topics relevant to the work of the board~~)) in advance of major votes or decisions, unless exigent conditions require otherwise.

(2) The board shall:

(a) Determine and require collection from payers and health care providers of the types and sources of data necessary to annually calculate total health care expenditures and health care cost growth, ((~~and to~~)) establish the health care cost growth benchmark, and analyze the impact of cost drivers on health care spending, including execution of any necessary access and data security agreements with the custodians of the data. The board shall first identify existing data sources, such as the statewide health care claims database established in chapter 43.371 RCW and prescription drug data collected under chapter 43.71C RCW, and primarily rely on these sources when possible in order to minimize the creation of new reporting requirements. The board may use data received from existing data sources, including, but not limited to, data collected under chapters 43.71, 43.71C, and 70.405 RCW, in its analyses and discussions to the same extent that the custodians of the data are permitted to use the data. The board also may use other available data sources, such as medicare cost reports. As appropriate to promote administrative efficiencies, the board may share its data with the prescription drug affordability board under chapter 70.405 RCW and other health care cost analysis efforts conducted by the state;

(b) Determine the means and methods for gathering data to annually calculate total health care expenditures and health care cost growth, and to establish the health care cost growth benchmark. The board must select an appropriate economic indicator to use when establishing the health care cost growth benchmark. The activities may include selecting methodologies and determining sources of data. The board shall ((~~accept~~)) solicit and consider recommendations from the advisory committee on data issues and the health care stakeholder advisory committee ((~~of health care providers and carriers~~)) regarding the value and feasibility of reporting various categories of information under (c) of this subsection, such as urban and rural, public sector and private sector, and major categories of health services, including prescription drugs, inpatient treatment, and outpatient treatment;

(c) Annually calculate total health care expenditures and health care cost growth:

(i) Statewide and by geographic rating area;

(ii) For each health care provider or provider system and each payer, ((~~taking into account~~)) both adjusted and unadjusted for the

health status of the patients of the health care provider or the enrollees of the payer, utilization by the patients of the health care provider or the enrollees of the payer, intensity of services provided to the patients of the health care provider or the enrollees of the payer, and regional differences in input prices to the extent data permits. The board may establish, in consultation with the advisory committee on data issues and the health care stakeholder advisory committee, a common risk adjustment methodology for use in relevant analysis. The board must develop an implementation plan for reporting information about health care providers, provider systems, and payers;

(iii) By market segment;

(iv) Per capita; and

(v) For other categories, as recommended by the advisory committees in (b) of this subsection, and approved by the board;

(d) Annually establish the health care cost growth benchmark for increases in total health expenditures. The board, in determining the health care cost growth benchmark, shall begin with an initial implementation that applies to the highest cost drivers in the health care system and develop a phased plan to include other components of the health system for subsequent years;

(e) Beginning in 2023, analyze the impacts of cost drivers to health care and incorporate this analysis into determining the annual total health care expenditures and establishing the annual health care cost growth benchmark. The cost drivers may include, to the extent such data is available:

(i) Labor, including but not limited to, wages, benefits, and salaries;

(ii) Capital costs, including but not limited to new technology;

(iii) Supply costs, including but not limited to prescription drug costs;

(iv) Uncompensated care;

(v) Administrative and compliance costs;

(vi) Federal, state, and local taxes;

(vii) Capacity, funding, and access to postacute care, long-term services and supports, and housing; ((~~and~~))

(viii) Regional differences in input prices; ((~~and~~ ~~(f)~~)) (ix) Financial earnings of health care providers and payers, including information regarding profits, assets, accumulated surpluses, reserves, and investment income, and similar information;

(x) Utilization trends and adjustments for demographic changes and severity of illness;

(xi) New state health insurance benefit mandates enacted by the legislature that require carriers to reimburse the cost of specified procedures or prescriptions; and

(xii) Other cost drivers determined by the board to be informative to determining annual total health care expenditures and establishing the annual health care cost growth benchmark;

(f) Levy civil fines on payers or health care providers that violate the board's data submission requirements, including the failure to submit data, the late submission of data, and the submission of inaccurate data. The board, in consultation with the advisory committee on data issues, shall develop a schedule of civil fines for the violation of data submission requirements that considers the nature of the violation and the characteristics of the violating entity. The board may not levy civil fines under this subsection on health care providers composed of 25 or fewer health care professionals licensed by a disciplining authority under RCW 18.130.040. The authority shall develop rules to implement this subsection, including a data process to verify provider counts; and

(g) Release reports in accordance with RCW 70.390.070.

Sec. 5. RCW 70.390.070 and 2020 c 340 s 7 are each amended to read as follows:

((~~(1) By August 1, 2021, the board shall submit a preliminary report to the governor and each chamber of the legislature. The preliminary report shall address the progress toward establishment of the board and advisory committees and the establishment of total health care expenditures, health care cost growth, and the health care cost growth benchmark for the state, including proposed methodologies for determining each of these calculations. The preliminary report shall include a discussion of any obstacles related to conducting the board's work including any deficiencies in data necessary to perform its responsibilities under RCW 70.390.050 and any supplemental data needs.~~

~~(2)~~)) Beginning August 1, 2022, the board shall submit annual reports to the governor and each chamber of the legislature. The first annual report shall determine the total health care expenditures for the most recent year for which data is available and shall establish the health care cost growth benchmark for the

following year. The annual reports may include policy recommendations applicable to the board's activities and analysis of its work, including any recommendations related to lowering health care costs, focusing on private sector purchasers, and the establishment of a rating system of health care providers and payers. Each report must include information about any testimony or public comments received in conjunction with the hearing mandated under section 8 of this act. Beginning with the August 1, 2024, annual report, the annual reports shall include an analysis of the underinsurance survey results obtained pursuant to section 6 of this act.

NEW SECTION. **Sec. 6.** A new section is added to chapter 70.390 RCW to read as follows:

(1) Beginning January 1, 2024, the board shall conduct an annual survey of underinsurance among Washington residents. The survey shall be conducted among a representative sample of Washington residents. Analysis of the survey results shall be disaggregated by demographic factors such as race, ethnicity, gender and gender identity, age, disability status, household income level, type of insurance coverage, geography, and preferred language. In addition, the survey shall be designed to allow for the analyses of the aggregate impact of out-of-pocket costs and premiums according to the standards in subsection (2) of this section as well as the share of Washington residents who delay or forego care due to cost.

(2)(a) The board shall measure underinsurance as the share of Washington residents whose out-of-pocket costs over the prior 12 months, excluding premiums, are equal to:

(i) For persons whose household income is over 200 percent of the federal poverty level, 10 percent or more of household income;

(ii) For persons whose household income is less than 200 percent of the federal poverty level, five percent or more of household income; or

(iii) For any income level, deductibles constituting five percent or more of household income.

(b) By January 1, 2026, the board shall recommend any improvements to the measure of underinsurance defined in (a) of this subsection, such as a broader health care affordability index that considers health care expenses in the context of other household expenses.

(3) The board may conduct the survey through the authority, by contract with a private entity, or by arrangement with another state agency conducting a related survey.

(4) Beginning in 2024, analysis of the survey results shall be included in the annual report required by RCW 70.390.070.

NEW SECTION. **Sec. 7.** A new section is added to chapter 70.390 RCW to read as follows:

(1) The board shall conduct a study of costs to the state, whether actual spending or foregone revenue collections, as related to nonprofit health care providers and nonprofit payers, that are not included in the calculation of total health care expenditures. The study shall evaluate how the consideration of state tax preferences, tax deductions, tax-exempt capital financing, and other public reimbursement and funding streams available to nonprofit health care providers and nonprofit payers would affect the calculation of total health care expenditures if they were included in the calculation.

(2) The study, as well as recommendations related to whether or not the costs to the state identified in subsection (1) of this section should be included in the calculation of total health care expenditures and incorporated into the health care cost growth benchmark, must be submitted by the board as a part of the August 1, 2025, annual report required under RCW 70.390.070.

(3) The board may conduct the study through the authority, by contract with a private entity, or by arrangement with another state agency conducting related work.

(4) This section expires January 1, 2026.

NEW SECTION. **Sec. 8.** A new section is added to chapter 70.390 RCW to read as follows:

(1)(a) Concurrent with the issuance of the annual report required under RCW 70.390.070, the board shall hold at least one public hearing related to discussing the growth in total health care expenditures in relation to the health care cost growth benchmark in the previous calendar year, as established in the annual report, in accordance with the open public meetings act, chapter 42.30 RCW. The agenda and any materials for this hearing must be made available to the public at least seven days prior to the hearing.

(b) The hearing shall include the public identification of any payers or health care providers for which health care cost growth in

the previous calendar year exceeded the health care cost growth benchmark.

(c) At the hearing, the board:

(i) May require testimony by payers or health care providers that have substantially exceeded the health care cost growth benchmark in the previous calendar year to better understand the reasons for the excess health care cost growth and measures that are being undertaken to restore health care cost growth within the limits of the benchmark;

(ii) Shall invite testimony from health care stakeholders, other than payers and health care providers, including health care consumers, business interests, and labor representatives; and

(iii) Shall provide an opportunity for public comment.

(2)(a) Except as provided in subsection (7) of this section, beginning July 1, 2024, the board may require that any payer or health care provider submit a performance improvement plan to the board if it has substantially exceeded the health care cost growth benchmark without reasonable justification or meaningful improvement for two of the previous three calendar years. The board must consider the factors identified in subsection (3)(b) of this section in determining whether a performance improvement plan is warranted. The performance improvement plan shall: Identify key cost drivers and include distinct steps that the payer or health care provider shall take to address costs exceeding the health care cost growth benchmark; identify an appropriate time frame by which a payer or health care provider will reduce costs to levels below the health care cost growth benchmark, subject to evaluation by the board; and have clear measurements of success, including progress reports. The first year that the board may consider in calculating the number of years of substantially exceeding the health care cost growth benchmark is calendar year 2021.

(b) By July 1, 2024, the authority, in consultation with the board, shall adopt rules related to the submission, content, and enforcement of performance improvement plans. The rules shall include a process to notify the payer or health care provider in advance of public notice that a performance improvement plan must be submitted and the areas of health care costs that are the source of the growth. The rules shall provide a reasonable opportunity to correct any practices causing excessive health care cost growth. The rules shall address appeals procedures to allow payers and health care providers

to seek review of a decision by the board to impose a performance improvement plan upon the payer or health care provider.

(3)(a) Except as provided in subsection (7) of this section, beginning July 1, 2025, the board may impose a civil fine on a payer or health care provider that either: (i) Substantially exceeded the health care cost growth benchmark without reasonable justification or meaningful improvement for three of the previous five calendar years; or (ii) fails to participate in a performance improvement plan. The first year that the board may consider in calculating the number of years of substantially exceeding the health care cost growth benchmark is calendar year 2021.

(b) By July 1, 2024, the authority, in consultation with the board, shall adopt rules related to the criteria for imposing a civil fine on a payer or health care provider, notifying the payer or health care provider in advance of public notice, providing a reasonable opportunity to correct any practices causing excessive health care cost growth, and establishing a civil fine schedule. The rules shall address appeals procedures to allow payers and health care providers to seek review of a decision by the board to impose a civil fine upon the payer or health care provider. In establishing the civil fine schedule, the authority shall account for:

(i) The amount and duration by which the payer or health care provider exceeded the health care cost growth benchmark, with initial civil fine amounts commensurate with the failure to meet the health care cost growth benchmark and escalating civil fine amounts beyond this initial civil fine amount for repeated or continuing failure to meet the benchmark;

(ii) The relative size and financial condition of the payer or health care provider, including revenues, reserves, profits, and assets of the entity, as well as any affiliates, subsidiaries, or other entities that control, govern, or are financially responsible for the entity or are subject to the control, governance, or financial control of the entity;

(iii) Quality performance data from reputable third-party sources regarding the payer or health care provider;

(iv) The good faith efforts of the payer or health care provider to address health care costs and cooperate with the board; and

(v) The relative starting price position of the payer or health care provider prior to the health care cost growth benchmark,

including but not limited to consideration of the primary care expenditure goal set forth in RCW 70.390.080.

(4) Except as provided in subsection (7) of this section, the authority may levy a reasonable fee on any payer or health care provider that is subject to a performance improvement plan or civil fine pursuant to this section to account for the authority's costs in developing and monitoring the plan or levying the civil fine. Any fees levied under this subsection must be used by the authority to offset administrative costs related to this chapter.

(5) The authority may waive the imposition of a performance improvement plan or civil fine in the event of unforeseen market conditions or if doing so would promote consumer health care access and affordability.

(6) Any fines levied under subsection (4) of this section or civil fines imposed under subsection (3) of this section must be deposited in the state health care affordability account established under RCW 43.71.130.

(7) The board may not impose performance improvement plans, fines, or fees under this section on health care providers composed of 25 or fewer health care professionals licensed by a disciplining authority under RCW 18.130.040. The authority shall develop rules to implement this subsection, including a data process to verify provider counts.

Sec. 9. RCW 43.71C.030 and 2019 c 334 s 4 are each amended to read as follows:

(1) By March 1st of each year, a pharmacy benefit manager must submit to the authority the following data from the previous calendar year:

(a) All discounts, including the total dollar amount and percentage discount, and all rebates received from a manufacturer for each drug on the pharmacy benefit manager's formularies;

(b) The total dollar amount of all discounts and rebates that are retained by the pharmacy benefit manager for each drug on the pharmacy benefit manager's formularies;

(c) Actual total reimbursement amounts for each drug the pharmacy benefit manager pays retail pharmacies after all direct and indirect administrative and other fees that have been retrospectively charged to the pharmacies are applied;

(d) The negotiated price health plans pay the pharmacy benefit manager for each drug on the pharmacy benefit manager's formularies;

(e) The amount, terms, and conditions relating to copayments, reimbursement options, and other payments or fees associated with a prescription drug benefit plan;

(f) Disclosure of any ownership interest the pharmacy benefit manager has in a pharmacy or health plan with which it conducts business; and

(g) The results of any appeal filed pursuant to RCW ((~~19.340.100(3)~~)) 48.200.280(3).

(2) The information collected pursuant to this section is not subject to public disclosure under chapter 42.56 RCW.

(3) The authority may examine or audit the financial records of a pharmacy benefit manager for purposes of ensuring the information submitted under this section is accurate. Information the authority acquires in an examination of financial records pursuant to this subsection is proprietary and confidential.

(4) Information collected pursuant to this section may be shared with the health care cost transparency board under chapter 70.390 RCW and other health care cost analysis efforts conducted by the state. Entities receiving information under this subsection are subject to the same disclosure restrictions as established under this chapter.

Sec. 10. RCW 70.405.030 and 2022 c 153 s 3 are each amended to read as follows:

By June 30, 2023, and annually thereafter, utilizing data collected pursuant to ((~~chapter~~)) chapters 43.71C, 43.371, and 70.390 RCW, ((~~the all-payer health care claims database,~~)) or other data deemed relevant by the board, the board must identify prescription drugs that have been on the market for at least seven years, are dispensed at a retail, specialty, or mail-order pharmacy, are not designated by the United States food and drug administration under 21 U.S.C. Sec. 360bb as a drug solely for the treatment of a rare disease or condition, and meet the following thresholds:

(1) Brand name prescription drugs and biologic products that:

(a) Have a wholesale acquisition cost of $60,000 or more per year or course of treatment lasting less than one year; or

(b) Have a price increase of 15 percent or more in any 12-month period or for a course of treatment lasting less than 12 months, or a 50 percent cumulative increase over three years;

(2) A biosimilar product with an initial wholesale acquisition cost that is not at least 15 percent lower than the reference biological product; and

(3) Generic drugs with a wholesale acquisition cost of $100 or more for a 30-day supply or less that has increased in price by 200 percent or more in the preceding 12 months.

NEW SECTION. **Sec. 11.** A new section is added to chapter 70.390 RCW to read as follows:

The authority may adopt rules independently or on behalf of the board, as necessary to implement this chapter.

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